Dr. William L. Rodman said that bone metastases in breast tumors are not particularly common, yet they are not extremely rare. Personally he has seen three cases. Two were unquestionably scirrhous carcinoma, the third was a sarcoma. In one of the carcinomas the metastastic growth was in the spine, the other in the left humerus, the same side as the primary tumor. The metastasis of the sarcoma was in the right femur six months after operation. The patient was the daughter of a prominent surgeon and had carried a benign growth for years.

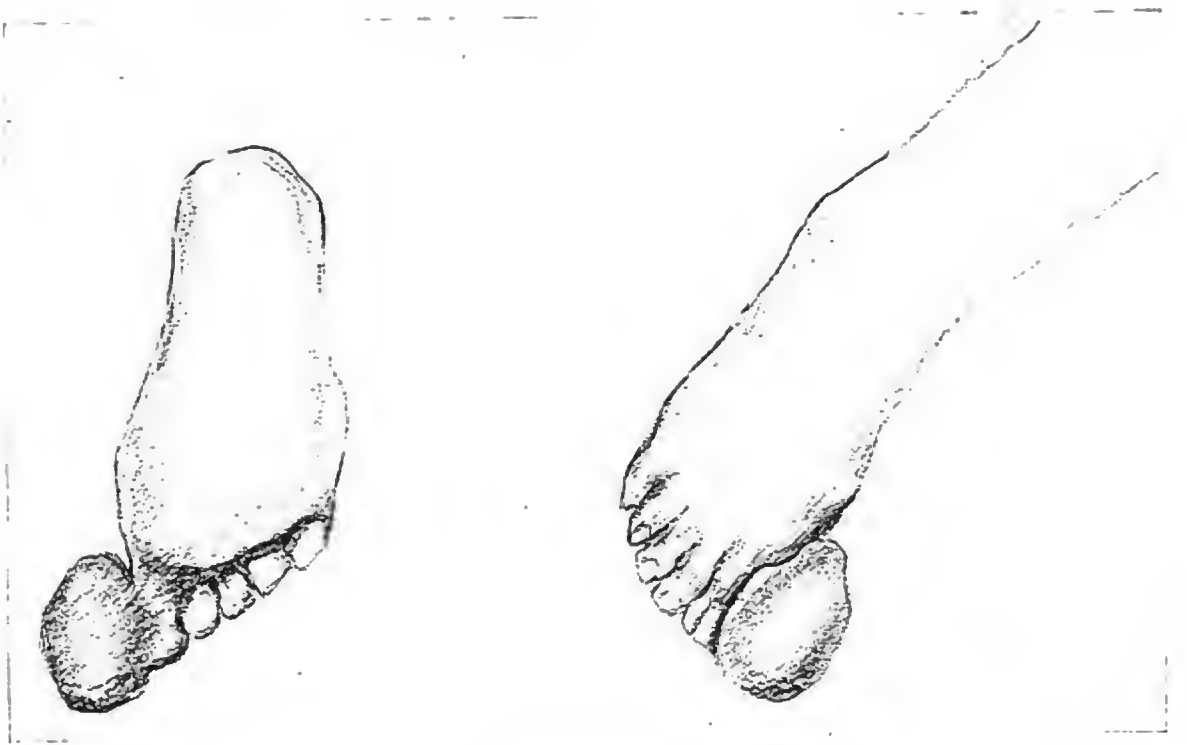
Metastasis in sarcoma is more easily understood as the cells are in contact with the wall of the vessels, while in carcinoma the vessels are in the stroma. He has seen many cases of bone involvement in the sternum, but there the reason is very plain. Of indirect infection he has seen only the two cases, it not being difficult to see how metastasis to the spine occurs. The retromammary lymphatics drain through the second and fourth interspaces and then run along the course of the intercostal arteries to the thoracic duct. In this way spinal metastases occur. Dr. Wharton said that primary cancer of the bone is rare; he questions if it ever occurs, as epithelial cells are not found in bone. Such tumors are really endotheliomata or sarcomata. Bone metastases are important as they are never located before operation. The same chains of lymphatics as previously mentioned also explain metastases to the liver; this being the most common site of the secondary growths.

Dr. John B. Roberts saw eight years ago a case similar to that reported by Dr. Wharton. He was not able to determine if a growth was present, but regarded it as probably a case of spinal metastasis.

FIBROMA OF THE GREAT TOE.

Dr. Henry R. Wharton reported the case of a man, aged 50 years, who noticed 12 years before he came under the care of Dr. Wharton a tumor of the right great toe; it was painless, but increased gradually in size. He found it necessary to have the shoe for the right foot made upon a special last to accommodate the increasing bulk of the tumor. A casual inspection of the feet with the shoes on showed no marked difference in their size. Within a few weeks a portion of the tumor had ulcerated and gave him pain, which caused him to apply for relief.

The tumor was a fibroma and was attached to the peri-



Fibroma of great toe.

osteum. It was removed without difficulty, the wound being covered by skin flaps dissected from the tumor. See Fig. 1.

POST-OPERATIVE TREATMENT.

Dr. John H. Gibbon read a paper with this title, for which see page 298.

Dr. John B. Deaver endorsed much that was said by Dr. Gibbon. He believes, however, that instead of patients being neglected they receive too much attention. His motto for the house physician is, "Let the patient get well." No medicine should be given after an operation as a rule. He is opposed to the indiscriminate and routine use of strychnin. He employs nothing but ether as an anæsthetic, being afraid of chloride of ethyl, as he has heard of deaths from it. Giving the anæsthetic is an important thing and ether usually does no harm. It is best to anæsthetize the patient on the operating table, as it is a mistake to move him there after ether is begun, this always meaning an extra amount of the drug. The patient may be anæsthetized in the high pelvic position even, the intestines thus being floated up and requiring less packing when the operation, being an abdominal one, is begun. When operating upon the upper abdomen he always has the patient wrapped in cotton and put upon a hot water bed; the cotton is at once removed when the patient is taken to his room.

As to scopolamin, Dr. Deaver does not know what it looks like and is thankful he does not. Tight sutures, as stated by Dr. Gibbon, make trouble; he usually places a drain in stout walls for a day. He was sorry to hear Dr. Gibbon say he uses morphin after operations; Dr. Deaver would at once discharge a resident if he did that. Its immediate effect is to make the patient more comfortable; after that it makes him more uncomfortable. It creates more thirst and often more nausea. Occasionally he employs morphia, but never as a routine measure. He administers oxygen immediately after operation and this lessens nausea, that fact being noted in the German Hospital by the Sisters who have been on duty for fifteen to twenty years. A careful nurse is of more moment than a hypodermic of morphia. There is not so much in the use of morphia after gastro-enterostomy as formerly supposed. When this operation is performed by making the communication with the jejunum as near as possible to its commencement vomiting does not occur.